



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DOCTORS CLINIC HOUSTON
14770 MEMORIAL DRIVE, SUITE 200
HOUSTON TX 77079

Respondent Name

FEDERAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 17

MFDR Tracking Number

M4-13-1398-01

MFDR Date Received

FEBRUARY 4, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We ask that the claim be processed for prompt payment; all documentation has been provided to the patient to further help her resume her duties for employment, we feel we have taken the necessary steps to help her through the process therefore, we request that this bill be reconsidered for prompt payment."

Amount in Dispute: \$1,913.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 22, 2011 January 22, 2011 February 2, 2012 February 23, 2012 March 15, 2012 April 12, 2012 May 10, 2012 June 7, 2012	CPT Code 99214 – Office Visit	\$174.00	\$0.00
December 22, 2011 January 22, 2011 February 2, 2012 February 23, 2012 March 15, 2012 April 12, 2012 May 10, 2012 June 7, 2012 August 2, 2012 September 27, 2012 October 15, 2012	CPT Code 99080-73 – Work Status Report	\$17.00	\$0.00

August 2, 2012 September 27, 2012 October 15, 2012	CPT Code 99213 – Office Visit	\$117.00	\$0.00
TOTAL		\$1,913.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. Texas Labor Code §408.023, effective September 1, 2009 sets out the responsibilities of the treating doctor.
3. 28 Texas Administrative Code §134.203 effective March 1, 2008, sets the reimbursement guidelines for the disputes service.
4. 28 Texas Administrative Code §134.204, effective March 1, 2008, sets out medical fee guidelines for workers' compensation specific services.
5. 28 Texas Administrative Code §129.5, effective July 16, 2000, sets out the procedure for reporting and billing work status reports.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- W1-Workers' Compensation State Fee Schedule Adj.
- 73-Work Status Report
- 058-No Authorization For Treatment
- 182-Reviewd as No Charge
- 150-Payment adjusted/unsupported service level
- 38-Svcs not provided/authorized by treating doctor
- 16-Not All Info for Adjudication was Supplied

Issues

1. Did the requestor waive the right to medical fee dispute resolution?
2. Does the documentation support that the treating doctor recommended the disputed treatment?

Findings

1. 28 Texas Administrative Code §133.307(c)(1) states: " Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section. (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The dates of service in dispute are December 22, 2011 through October 15, 2012. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on February 4, 2013. Dates of service December 22, 2011 through February 2, 2012 are later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307, subparagraph (B). The Division concludes that the requestor has failed to timely file dates of service December 22, 2011 through February 2, 2012 this dispute with the Division's MDR Section; consequently, the requestor has waived the right to medical fee dispute resolution for dates of service December 22, 2011 through February 2, 2012.
2. According to the explanation of benefits, the respondent denied reimbursement for the disputed services based upon reason codes "058 and 38."

Texas Labor Code §408.023(l) states "The injured employee 's treating doctor is responsible for the efficient management of medical care as required by Section 408.025(c) and commissioner rules."

According to Division records on the disputed dates of service, the claimant's treating doctor was Allen R. Dorsett, M.D. The requestor, Dr. Avinash Parti became the claimant's treating doctor on March 5, 2013.

The requestor submitted a copy of a CorCare Application For Change In Treating Doctor report dated November 17, 2011 requesting to change doctors to Dr. Parti. This report and request were not through the Division, rather through the respondent's representative Corvel. The Division did not approve the change in treating doctors until March 5, 2013.

The Division finds that the submitted documentation does not support a referral for treatment from the treating doctor to Dr. Parti; therefore, the respondent's denial based upon reason codes "058 and 38" are supported. As a result, reimbursement cannot be recommended.

Conclusion

The Division finds that the requestor has waived the right to medical fee dispute resolution for the services in dispute dated December 22, 2011 through February 2, 2012.

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	9/13/2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.